

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11477

11454

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Howard

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fulton

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Fairview Farm

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Howard

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Highland

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First J. BEAUSOLEIL

Middle

Last

4. DATE
OF
DEATH

Oct. 8, 1960

19

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

9. AGE (In years
last birthday)

Aug. 8, 1895

65

yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Farm Labor

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pittsfield, Mass.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, No, or Unknown)
(If yes, give war or dates of service)

Yes

WW 1

16. SOCIAL SECURITY NO.

578-16-8529

17. INFORMANT

Joseph Thompson, Fulton, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

5 mins.

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

o. m.

p. m.

19

20d. INJURY OCCURRED

While
at work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

Charles S. Whitaker

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

10-9-60

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

Burial

10-12-1960

Arlington National

Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

F.C. Higinbotham, Ellicott City, Md

24a. REC'D BY REGISTRAR

DATE

OCT 13 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

WILDCAT GROWLERS® CATCHES THE DESIGN

CONTINUOUS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11478

CERTIFICATE OF DEATH

11455

Reg. Dist. No.

1		M		11478		CERTIFICATE OF DEATH		11455	
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		TO		TO		TO	
1		M		Howard		MARYLAND		Maryland	
2		a. PLACE OF DEATH o. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
3		Howard		Elkridge				a. STATE Maryland	
4		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Howard			
5		5609 main st		X Ellicott City (rural)					
6		3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?			
7		Clyde Cecil Dennis		Kerger Road		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
8		4. DATE OF DEATH		Month Oct. 17		Day 1960			
9		5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
10		Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb. 23, 1886	
11		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
12		Farmer (For himself)		Truck farming		Maryland		U. S. A.	
13		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
14		George William Dennis		Alice Dwyer					
15		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
16		No		Mrs. Nathal C. Dennis Kerger Rd. Ellicott City,				Md.	
17		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH	
18		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO		10 min		527.1	
19		{ (b)		DUE TO		3 mos		Ch. myocarditis	
20		{ (c)		DUE TO		10 yrs		Compensation Ch. myocarditis	
21		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED?	
22		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				YES <input type="checkbox"/> NO <input type="checkbox"/>	
23		20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
24		21. I certify that I attended the deceased from Sept 19, 1960 to Oct 17, 1960 that I last saw the deceased alive on Sept 17, 1960, and that death occurred at 4:15 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
25		ACTUAL SIGNATURE		B. B. Brumbaugh		7609 main st Ellicott City		10/18/60	
26		PHYSICIAN'S NAME (Type)		B. B. Brumbaugh					
27		22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
28		Burial		10/20/1960		Grace Church Cemetery		Elkridge, Md.	
29		23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
30		Easton Sons		Catonsville, Md.		DATE OCT 24 '60		John S. Kuhn	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11479

CERTIFICATE OF DEATH

11456
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge Halethorpe		c. LENGTH OF STAY IN 1b X Halethorpe - Elkridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2104 Forrest Ave., Zone 27		e. STREET ADDRESS 2104 Forrest Avenue	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle E.	Last DUBBS
4. DATE OF DEATH Oct. 23	Month Oct.	Day 23	Year 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/1888
9. AGE (In years last birthday) 72	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) operator	10b. KIND OF BUSINESS OR INDUSTRY Chesapeake Shoe Co	11. BIRTHPLACE (State or foreign country) Hampstead, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas E. James	14. MOTHER'S MAIDEN NAME Adeline Mahala		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Thomas B. Dubbs, husband, above	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
Cesophagitis & Hemorrhoids 1 day Cerebral Hemorrhage, 10 yrs General Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> oil work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>60</u> , to <u>Oct 29, 1960</u> , that I last saw the deceased alive on <u>Oct 23, 1960</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE B.B. Brumbaugh	ADDRESS (Street, city or town, state) 1609 main st Elkridge 27 md DATE SIGNED 10/24/60		
PHYSICIAN'S NAME (Type) B.B. Brumbaugh			
22d. BURIAL, CREMATION, REMOVAL (Specify) Burial	22e. DATE THEREOF 10/27/60	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	22d. LOCATION (City, town, or county) Baltimore, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home 3331 Brehms Lane	ADDRESS	24a. REC'D BY REGISTRAR DATE OCT 26 '60	24b. REGISTRAR'S SIGNATURE Caroline L. Krause

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11457

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Savage</i>		c. LENGTH OF STAY IN 1b <i>10 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Savage</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Savage</i>			
d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Horace L. Fairall</i>		First <i>Horace</i>	Middle <i>L.</i>		
4. DATE OF DEATH <i>October 31, 1960</i>		Month <i>October</i>	Day <i>31</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 7, 1889</i>		
9. AGE (In years last birthday) <i>71 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Member of electric construction</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>William A. Fairall</i>	14. MOTHER'S MAIDEN NAME <i>Mary Theresa Brennan</i>	Address <i>Aura Fairall, Savage, Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>379-12-4892</i>	17. INFORMANT <i>Laura Fairall</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153</i> DUE TO <i>Carcinoma Lung-Liver</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Carcinoma of Sigmoid</i> (c) DUE TO <i>=</i>	INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>1</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>1</i>			
20c. TIME OF INJURY Month, Doy, Year Hour o. m. <i>19</i> p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1</i>	20f. (City or town) <i>1</i>	(County) <i>1</i>	(State) <i>1</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 28, 1960</i> to <i>Oct 31, 1960</i> that (I) (we) last saw the deceased alive on <i>Oct 30, 1960</i> , and that death occurred at <i>6 K</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>H. B. Steward</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>1</i>		
22c. PHYSICIAN'S NAME (Type) <i>H. B. Steward</i>		22d. ADDRESS <i>314 Compian an Laurel Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Nov 2, 1960</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St Marys Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Laurel, Maryland</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Danaldson, Laurel, Md</i>		ADDRESS <i>1</i>	25a. REC'D BY REGISTRAR <i>1</i>	25b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	DATE <i>Nov 4, 1960</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11459

1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville		c. LENGTH OF STAY IN 1b		b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First MAMIE	Middle ISENNOCK	Last	4. DATE OF DEATH Oct. 28, 1960	Month Oct.	Day 28	Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1883		9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Co. Md		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Joseph Meyers				14. MOTHER'S MAIDEN NAME Fianna Mumma					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. Muriel Johnston, Clarksville, Md			
No		-							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO Cerebral Embolus. 10 min. Coronary Dis. Myocarditis 1 yr. Cardiac Dil. 1 mo.									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Doy, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that (I) (this hospital) attended the deceased from 10/19 1960 to 10 1960 that (I) (we) last saw the deceased alive on 10/25 1960 and that death occurred at 3:15 P.M. from the causes and on the date stated above.									
22a. SIGNATURE B.P. Warren		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/25/60					
22c. PHYSICIAN'S NAME (Type) B P WARREN		22d. ADDRESS Laurel Mid							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-31-60		23c. NAME OF CEMETERY OR CREMATORIAL Fork Meth. Church Cem.		23d. LOCATION (City, town, or county) Fork Md			(State)
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 1 '60			25b. REGISTRAR'S SIGNATURE Charles E. Krause		
VR A15 (4) 15M 9/59									

Mr. and Mrs. David
and their son
John

21. 03. 1951
Mr. and Mrs. David
and their son
John

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11474

CERTIFICATE OF DEATH

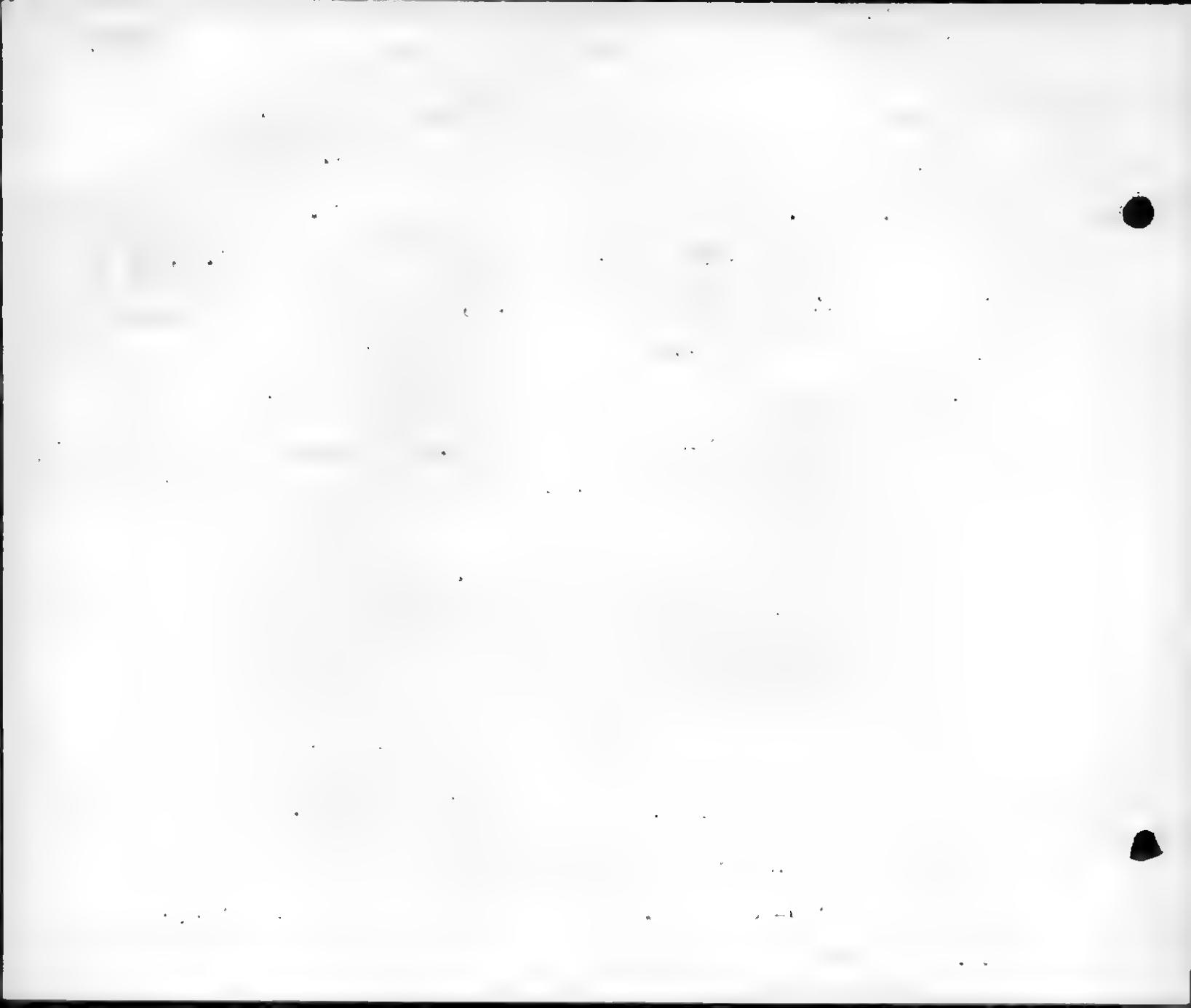
11460

Reg. Dist. No.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN Tb 342 W. Main St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 342 W. Main St.		e. STREET ADDRESS 342 W. Main St.	
3. NAME OF DECEASED (Type or print) WILLIAM HENRY MOORE		First WILLIAM	Middle HENRY
4. DATE OF DEATH Oct. 19, 1960		Month Oct.	Day 19
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH Apr. 11, 1883		9. AGE (In years lost birthday) 77	10. IF UNDER 1 YEAR yrs. 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	11. BIRTHPLACE (State or foreign country) Ilchester, Md
12. CITIZEN OF WHAT COUNTRY? Eliza Jane Grace		13. FATHER'S NAME Phillip Moore	
14. MOTHER'S MAIDEN NAME Woodrow W. Moore, Montgomery Road, Ellicott City		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 217-07-5732		17. INFORMANT Eliza Jane Grace	18. ADDRESS Woodrow W. Moore, Montgomery Road, Ellicott City
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Diabetes Mellitus.		3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) White Not white at work	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 10, 1957 , to Oct. 18, 1960 , that I last saw the deceased alive on Oct. 18, 1960 , and that death occurred at 59 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Ellicott City, Md.	
ACTUAL SIGNATURE William F. Gassaway		DATE SIGNED 10/18/60	
PHYSICIAN'S NAME (Type) William F. Gassaway M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-60	22c. NAME OF CEMETERY OR CREMATORIAL St. Johns
22d. LOCATION (City, town, or county) Ellicott City, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.		24a. REC'D BY REGISTRAR OCT 24 '60	24b. REGISTRAR'S SIGNATURE C. G. Higinbotham



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11481

11461

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH — COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
				a. STATE Maryland	
				b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City rural		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Residence 5 mile west of Ellicott City				d. STREET ADDRESS Rt. 144 5 mile west Ellicott City	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOSEPH ELLWOOD NOLL		First	Middle	Last	4. DATE OF DEATH October 8, 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH July 15, 1958	9. AGE (in years last birthday) 2 yrs.
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>			10. UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
13. FATHER'S NAME Hart Benton Noll		14. MOTHER'S MAIDEN NAME Beverly Ann Fleming		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Dorothy Noll, Bethany Lane, Ellicott City, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE Extensive Compound Comminuted Skull Fracture				INTERVAL BETWEEN ONSET AND DEATH Instant	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8/12 X		(b) DUE TO			
		(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Truck backing out of drive ran over child's head			
20c. TIME OF INJURY Hour 11-40-60		Month, Day, Year 10-8-60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	(County) Ellicott City (State) Howard Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>George E. Burgtorf</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-8-60	
EXAMINER'S NAME (Type) George E. Burgtorf					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-60	22c. NAME OF CEMETERY OR CREMATORIUM Good Shepherd	22d. LOCATION: (City, town, or county) Ellicott City, Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS	24a. REC'D BY REGISTRAR DATE OCT 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail carbon copy. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11462

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5831 Virlona Ave		d. STREET ADDRESS 5831 Virlona Ave	
3. NAME OF DECEASED (Type or print) ROSEMARY A O'MALLEY		4. DATE OF DEATH Oct. 31, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator C&P Co.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Howard Co., Md.	
13. FATHER'S NAME Charles F. Smithson		14. MOTHER'S MAIDEN NAME Mary C. Bush	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-03-6840	
17. INFORMANT Rosemary M. Ford, 1815 Augustine Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
<p>Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</p> <p><i>acute coronary occlusion due to char 110 mg. laudanum</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.</p> <p>(b) DUE TO <i>char 110 mg. laudanum</i></p> <p>(c) DUE TO <i>acute coronary occlusion due to char 110 mg. laudanum</i></p>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1955 to Oct 31, 1960</i> that (I) (we) last saw the deceased alive on <i>Oct 30, 1960</i> and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Rosemary M. Ford</i>		22b. DATE SIGNED <i>11/1/60</i>	
22c. PHYSICIAN'S NAME (Type) B. B. Brumbaugh		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>2609 Main St. Elkridge 27-112</i>	
23a. BURIAL/CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 11/3/60	
23c. NAME OF CEMETERY OR CREMATORIAL St Augustine		23d. LOCATION (City, town, or county) Howard Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
25a. REC'D BY REGISTRAR DATE NOV 3 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

12

1 TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be required by the hospital or attending physician.

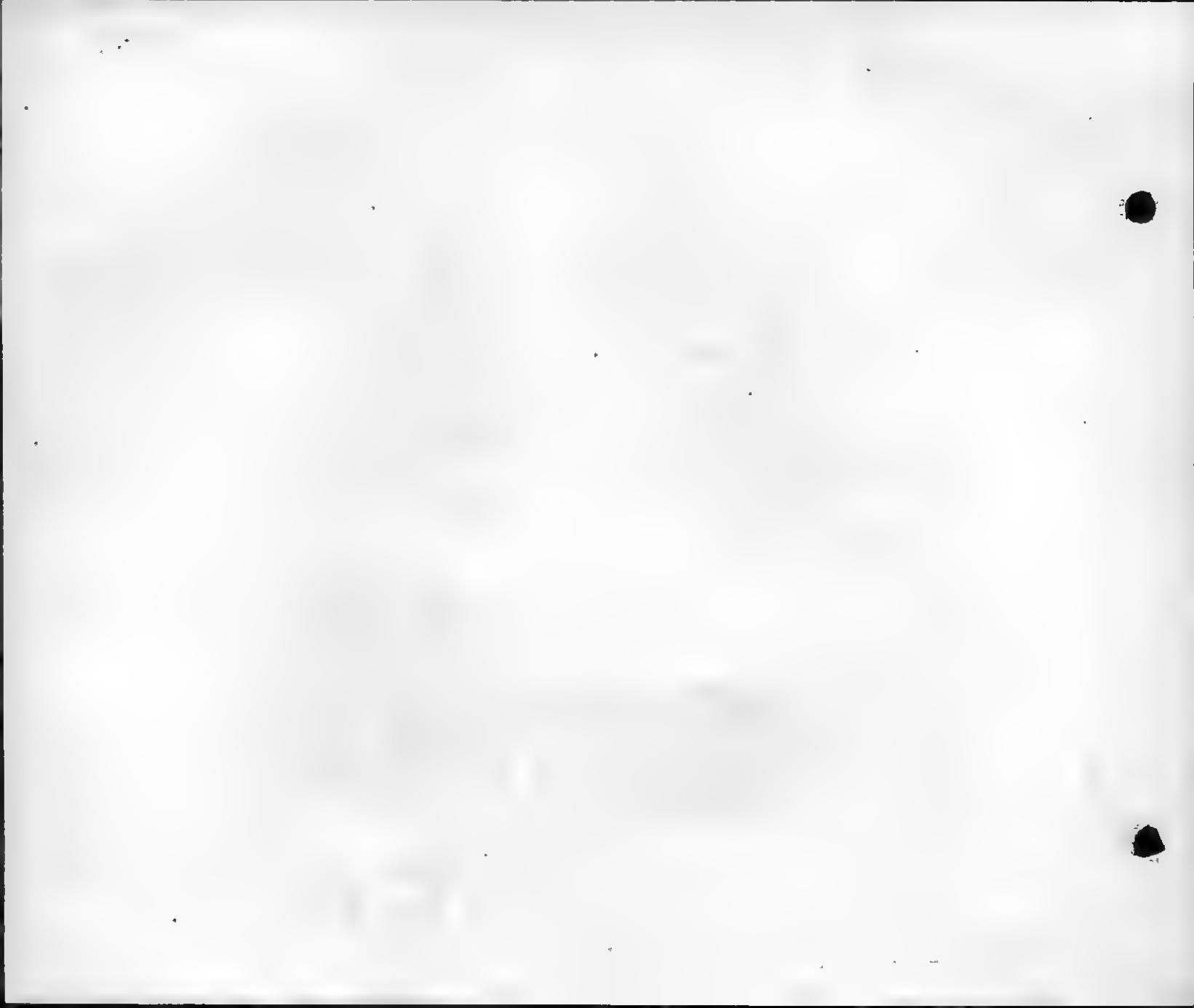
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11475 11463

1. PLACE OF DEATH a. COUNTY Howard			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			c. LENGTH OF STAY IN 1b 22 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charles			First Charles	Middle G.	Last Polacek
4. DATE OF DEATH October 17			Month October	Day 17	Year 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/7/09	9. AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lead Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Martin Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Henry J. Polacek		
14. MOTHER'S MAIDEN NAME Maria Kopecky			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Marie Bendall, sister, 1404 Gittings Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			Address Zone 12		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1			Myocardial infarction		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			DUE TO (b)		
			DUE TO Coronary occlusion		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension; arterial			INTERVAL BETWEEN ONSET AND DEATH 8 hrs.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept 26 1960 to Oct 17 1960 , that (I) (we) last saw the deceased alive on Oct 17 1960 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. SIGNATURE Stephen Lee Magness			22b. DATE SIGNED 10/17/60		
22c. PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D.			22d. ADDRESS Taylor Manor Hospital, Ellicott City Md.		
23a. BURIAL, CREMATON. REMOVAL (Specify) Burial		23b. DATE THEREOF 10/21/60		23c. NAME OF CEMETERY OR CREMATORIUM Bohemian National Cem	
23d. LOCATION (City, town, or county) Baltimore, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc.			25a. REC'D BY REGISTRAR DCT 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause
ADDRESS 2001-03-05 E. Madison St.			DATE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. Daugherty - After 30 P.M.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										11464					
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY Howard					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.					b. COUNTY Howard					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridge Road					d. STREET ADDRESS Box 13 A. Ridge Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Lavinia I. Roth			Middle		Last		4. DATE OF DEATH 10/16/60		Month	Day	Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 16, 1912		9. AGE (In years last birthday) 48		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME George T. Akehorst					14. MOTHER'S MAIDEN NAME Sarah A. Kenny										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT none Geo. A. Roth, Ridge Rd., Elkridge, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO cancer - breast (c) DUE TO cancer - breast 3 yrs										INTERVAL BETWEEN ONSET AND DEATH 3 yrs					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour a. m. p. m.					20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County)		(State)		
21. I certify that (I) (this hospital) attended the deceased from 10/15/60 to 10/16/60, that (I) (we) last saw the deceased alive on 10/15/60, and that death occurred at 10/16/60 M, from the causes and on the date stated above.															
22a. SIGNATURE Dr. Daugherty					M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE 5 GENED 10/16/60		
22c. PHYSICIAN'S NAME (Type) A. Bradley Daugherty, M.D. 1264 Francis Avenue					22d. ADDRESS 1264 Francis Ave. -27-										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/60		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood					23d. LOCATION (City, town, or county) Baltimore, Md. (State)						
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Ave.					25a. REC'D BY REGISTRAR DATE OCT 20 '60					25b. REGISTRAR'S SIGNATURE Cirrus S. Knob					



1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

11481
1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11465

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	
d. STREET ADDRESS Clarksville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRED		First MIDDLE Louis	4. DATE OF DEATH Month Day Year October 10, 1960
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH August 26 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 1
13. FATHER'S NAME Howard Smith		11. BIRTHPLACE (State or foreign country) Olney, Md	12. CITIZEN OF WHAT COUNTRY?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. None	17. INFORMANT Phyllis Harris Howard Smith 323 Ellen St. NW Washington D.C. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 391.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) bilateral otitis media DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-11-60	22c. NAME OF CEMETERY OR CREMATORIAL Carver Memorial
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		22d. LOCATION (City, town, or country) (State) Laurel, Md	
24a. REC'D BY REGISTRAR 1000214XV3		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11485

CERTIFICATE OF DEATH

11466

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Howard				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover		d. STREET ADDRESS Anderson Ave.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anderson Ave.				d. STREET ADDRESS Anderson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH 10/22/60	Month	Day	Year 19		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/12/ 1878	9. AGE (In years last birthday) 82	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Joseph H. Talbott		14. MOTHER'S MAIDEN NAME Kate Ray								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Thomas F. Talbott Hanover, Md.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Bacillus pneumoniae (bacilli) Chro. Myco. coryneb. 6 mos Salmonella 5 yrs cerebral Dehydration, cause unknown								
DUE TO (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) cerebral Dehydration, cause unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 6, 1960</u> to <u>Oct 22, 1960</u> that (I) (we) last saw the deceased alive on <u>Sept 19, 1960</u> and that death occurred at <u>5:57 PM</u> , from the causes and on the date stated above.									22b. DATE SIGNED 10/24/60	
22a. SIGNATURE B. B. Brumbaugh		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/24/60				
22c. PHYSICIAN'S NAME (Type) B. B. Brumbaugh		22d. ADDRESS 7609 Main St Elkhridge								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/60		23c. NAME OF CEMETERY OR CREMATORIAL St. Augustines		23d. LOCATION (City, town, or county) Elkridge, Md.		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR DATE OCT 25 '60		25b. REGISTRAR'S SIGNATURE Ortha S. Kraus				

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